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| https://intranet.mercyhealth.com.au/about-us/PublishingImages/HighRes_Mercy%20Health_Full%20Colour%20Logo.jpg | **Werribee Mercy Hospital Outpatient Clinics Referral Form** | |
| To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 300 Princes Highway, Werribee Vic 3030 | **Phone:** 03 8754 6700 **Fax:** 038754 6710 |

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| **Patient Details** | | | | | | | | **Previous WMH patient?** | | | | | | | | | | | | |  | | **Yes** | | | |  | **No** |
| **Full Name:** | |  | | | | | | | **ATSI - Self:** | | |  | | | | | | | | | | | | | | | | | |
| **Date of Birth:** | |  | | | | | | | **ATSI - Spouse:** | | |  | | | | | | | | | | | | | | | | | |
| **Address:** | |  | | | | | | | **Eligible for Medicare?** | | | |  | | **Yes** | | |  | | | **No** | | | | | | | | |
| **Suburb:** | |  | | | **Post Code:** | | |  | **Medicare No:** | |  | | | | | **IRN:** | | |  | | | | **Exp. Date:** | | | |  | | |
| **Phone (H):** | |  | | | | | | | **Health Insurance Fund:** | | | | |  | | | | | | | | | | | | | | | |
| **Mobile:** | |  | | | | | | | **Health Insurance No.:** | | | | |  | | | | | | | | | | | | | | | |
| **Interpreter Required?** | | |  | **Yes** | |  | **No** | | **Disability or special needs:** | | | | | | | |  | | | **Yes** | | | | |  | **No** | | | |
| **Language:** | |  | | | | | | | **Specify**: |  | | | | | | | | | | | | | | | | | | | |

**Referring Doctor**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Print name: Designation:** | | | | | | **Provider no.:** |
| **Practice Name & Address:** | | | | | | |
| **Postcode:** |  | **Phone:** |  | **Fax:** |  | |

**Patient Information**

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| --- | --- | --- | --- | --- | --- |
| **Height (cm):** | Click here to enter text. | **Weight (kg):** | Click here to enter text. | **BMI:** | *Click here to enter text.* |

**Reason for Referral / Diagnosis**

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**Relevant co-morbidities / past medical/surgical/ mental health / genetic / family history:**

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**Medicines & Allergies:**

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**Investigations Ordered: (Please attach all relevant results to assist us to triage correctly)**

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**Doctor’s signature: Date:**

**You should receive written notification from us within 8 working days confirming receipt of your referral. Failure to supply all the required information may lead to a delay in your referral being processed as we may need to seek the additional information.**

**Pages to follow (including cover sheet):**

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